PIALEMEN	IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2)-MIII	TIPLE CONSTRUCTION	OMB NO	M APPROV 0. 0938-0:
WILL IS LEAST	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE SURVEY COMPLETED	
			B. WING		J JOINT	
NAME OF	PROVIDER OR SUPPLIER	44E200	B. WING		12/	21/2010
	BROOK SANITARIUM	· Androne) st	REET ADDRESS, CITY, STATE, ZIP CODE		
		()(1. PC		114 CAMPUS DRIVE DAYTON, TN 37321		
(X4) ID PREFIX	SUMMARY STATE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	/ ip	PROVIDER'S PLAN OF CORRECT	TION	T
TAG	NEGOLATORY OR LS	C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	MADE	COMPLET DATE
F 000	INITIAL COMMENT	S	F 000	District	· · · · · · · · · · · · · · · · · · ·	
				Disclaimer Statemen	<u>t</u>	12-31-1
	During complaint inv	restigation number 26676,		Laurelbrook Nursing Home of believe and does not admit the	oes not	
ĺ	14 -21, 2010 at Lau	6890 conducted on December relbrook Sanitarium, no		deficiencies exist, before, du	iat any	
I	deficiencies were citi	ed in relation to the		after the survey. Laurelbrook	tring allo	
1	complaints under 42	CFR Part 482 13		Nursing Home reserves all ri	s ohts to	
F 157	Requirements for Lo 483.10(b)(11) NOTIF	ng Term Care.	_	contest the survey findings th	rough	
SS=D	(INJURY/DECLINE/F	ROOM, ETC)	F 157	informal dispute resolution, f	ormal	
- 1		3) I	İ	appeal proceeding or any	20	
	A facility must immed	diately inform the resident;		administrative or legal proces	edings.	
	known, notify the resid	ent's physician; and if dent's legal representative		This plan of correction is not	meant	
1.7	or an interested famil	V member when there is an		to establish any standard of c	are,	
1 1	accident involving the	resident which regulte in	ĺ	contract obligation or position	n and	*
ļi	intervention; a signific	tential for requiring physician cant change in the resident's	-	Laurelbrook Nursing Home re	eserves	30 m
13	physical, mental, or p	SVChosocial status (i.e. a.		all right to raise all possible contentions and defenses in a		
	referioration in health	. mental or nevelopeople!		of civil or criminal claim, acti	ny type	108
	All Hical complications	eatening conditions or ; a need to alter treatment	1	proceedings. Nothing contain	ed in	
5	agrimoantiy (i.e., a ne	ed to discontinue an	İ	this Plan of Correction should	be	
, e	existing form of treatm	nent due to adverse		considered as a waiver of any		
t	reatment); or a decision	commence a new form of on to transfer or discharge		potential applicable Peer Revi	ew,	
เ	ie resident from the f	acility as specified in	1	Quality Assurance or self criti	cal	
§	483.12(a).			examination privileges which		
T	i he facility must also r	promptly notify the resident		Laurelbrook Nursing Home de	oes not	
l d	nu, if known, the resid	dent's legal representative	,	waiver, and reserves the right	to	
U	i interested ramily me	ember when there is a		assert in any administrative, ci criminal claim, action or	vil, or	
SI	pecified in §483.15(e	mmate assignment as		proceedings. Laurelbrook Nur	reina	
16	sident rights under F	ederal or State law or		Home offers its responses, cre	dible	
) re	gulations as specified is section.	d in paragraph (b)(1) of		allegations of compliance and	plan	
l in	ιο σεφηση.			of corrections as part of its one	zoing	
TI	ne facility must record	and periodically update		efforts to provide quality of ca	re to	
th	e address and phone	number of the resident's	1	residents.	A-1-13 (1995)	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

	CENT	RTMENT OF HEALTH ERS FOR MEDICARE	& MEDICAID SERVICES		2	FORM	D: 12/29/201 W APPROVEI
1	ND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE :	0. 0938-039 SURVEY LETED
_			44E200	B. WING			
	NAME OF	PROVIDER OR SUPPLIER				12/	21/2010
	LAURE	LBROOK SANITARIUM	ſ	- 1	REET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321		
	(X4) ID PREFIX TAG	(CACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	CHIDDE	(X5) COMPLETION DATE
		legal representative This REQUIREMEN by: Based on medical re review, observation failed to ensure the idevelopment of pres (#15) of eleven resid sores. The findings included Resident #15 was ac 30, 2009 with diagno Injury with Base Skul Hemorrhage and Dia Medical record review dated October 14, 20 no problems with sho deficits; decision make required supervision than for mobility; exp both sides of upper all was continent of bowe Medical record review Medical record review	or interested family member. IT is not met as evidenced ecord review, facility policy and interview, the facility physician was notified of the isure sores for one resident lents reviewed for pressure It imitted to the facility on June ses to include Closed Head Il Fracture, Intracranial libetes. It of the Minimum Data Set to or long term memory ting skills was not impaired; to limited assistance with and hygiene; used a wheel erienced impairment on and lower extremities and all and bladder.	1	F-157 1) Resident #15's physical notified regarding wou 12/31/10 by DON. 2) 100% audit was completed DON on 12/31/10 on all with pressure sores for protification. Aberrances corrected immediately. 3) The policy and proceed physician notification was respectively by the DON on 12/31/10. Evaluation was provided to the nursing 12/31/10 by DON regarding policy and procedure. Weel assessments will be completed by the Direct Nursing monthly to ensure plantification. Aberrances we corrected immediately. Resulting devices will have	ian was nds on ed by the residents ohysician s were dure for eviewed ducation staff on ing this kly skin eted by s will be ctor of hysician vill be esidents devices cation ON for by the	12-31-10
		been identified as bei breakdown.	ealed the resident had not ng at risk for skin		residents with devices and wissues weekly for four weeks,	ith skin	

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foot brace..."

Interview with Licensed Practical Nurse (LPN) #2

revealed the resident required "...supervision or

break down of a blister on the right foot from the

assistance with activities of daily living...skin

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immediately.

DON. Aberrances will be corrected

continue monthly for three months.

These audits will be reviewed

quarterly by the QA committee for

further recommendations.

These audits will

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DEPA	RTMENT OF HEALTH	AND F" AN SERVICES			PRINTE	D: 12/29/201 M APPROVEI
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION	OMB NO. 093 (X3) DATE SURVE COMPLETED	
		44E200	B. WING	· · · · · · · · · · · · · · · · · · ·		
NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		TOSET ASSESSED OF	12/	21/2010
	LBROOK SANITARIUN			TREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321	100	
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F 157	Continued From pag	ge 2	F 15	7		12-81-10
4	resident required the and braces for both apply brace to right! the right shoe "built ago and the brace no brace was causing "social worker had so appointment to have December 16, 2010 cancelled.	dent's room on December 20, with the resident revealed the e use of specialized shoes lower legs; was unable to eg by self; had the outside of up" about three to four weeks eeded adjusting now as the sores" on the right foot; the heduled the resident an the brace adjusted on but the appointment was			2	
	revealed "we're (nuthe blister and padding revealed after remove brace, no dressing or resident's foot and the (centimer) reddened area in the center with upper outer aspect of reddened area on the non-blanchable (did not not not not not not not not not not	at 9:40 a.m., with LPN #2 Irsing staff) putting salve on Ing the area" Observation Ing the resident's sock and I padding was present on the I paddin				

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DEPARTMENT OF HEALTH AND F" 'AN SERVICES PRINTED: 12/29/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 44E200 NAME OF PROVIDER OR SUPPLIER 12/21/2010 STREET ADDRESS, CITY, STATE, ZIP CODE LAURELBROOK SANITARIUM 114 CAMPUS DRIVE DAYTON, TN 37321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PREFIX (X5) COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 157 Continued From page 3 F 157 Appointment scheduled for December 16, 2010. Resident notified." Continued review revealed "December 20, 2010 at 3:09 p.m., (Social Services noted) December 16, 2010 appointment with (named clinic) cancelled due to snow and ice. Appointment rescheduled for December 30 at 11:30 a.m. Resident notified," Medical record review of the Physician's Progress notes revealed no documentation of skin breakdown for November or December 2010. Review of the facility policy Pressure Sores revealed "... 5. The physician will be in charge of the plan of care and provide appropriate orders for resolution of the pressure sore..." Interview in the sun room on December 21, 2010

F 314 SS≃G

483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and

at 12:25 p.m., with the Director of Nursing (DON), Director of Nursing in Training (DONIT), and Minimum Data Set and Care Plan Coordinator confirmed there was no documentation available to indicate the physician was notified of the change in the resident's skin to obtain orders for treatment of the pressure sore. Continued interview confirmed the facility failed to ensure the physician was notified of resident's changes in

F 314

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skin condition.

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CENTE	RS FOR MEDICAR				FORM): 12/29/20 MAPPROVE): 0938-03
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S	SURVEY
		44E200	B. WING_			
NAME OF	PROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CO	1 12/2	21/2010
10.	BROOK SANITARIU		1	14 CAMPUS DRIVE DAYTON, TN 37321		
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Fygire	by: by: by: assed on medical facility document re interview, the facility provide care and tr to prevent deterior one resident (#1) a assess/pressure ul resident (#15) resu #15); failed to ensu #15); failed to ensu #15); failed to ensu #15); failed to ensu #16); failed to ensu #17); failed to ensu #18); in from developing. INT is not met as evidenced record review, observation, eview, facility policy review and ty failed to routinely assess and reatment of two pressure ulcers for not failed to prevent cer development for one liting in harm to residents (#1, re residents identified at risk droutine skin assessments on or two residents (#5, #11) of viewed for pressure ulcers. Initited to the facility on ith diagnoses including tita, Psychosis and Bowel and received the Minimum Data Set note date of June 8, 2010 at had a Stage 2 pressure at MDS with a reference date 10 revealed the resident had e ulcers. Plan revealed the resident standard mattress, used a source and record and recor		F 214	2/22/10 and Wound and the by ADON ders were 's wound's e Nurse on ed on the Worksheet by on obtained. Simeasured '23/10 and Wound physician Nurse on obtained. By ADON ted on the Worksheet by ADON ders were completed Nurse by kin issues e Wound and the contacted	12 31 11	

Medical record review revealed three September
Wound Assessment Worksheets. The
assessments for the 9th and 17th of September
did not include ulcer measurements and were
completed by an Registered Nurse (RN) who
identified two areas within the ulcer as "stage 2,"
and one area as "stage 3 with thick white edge."
Record review revealed the same RN
documented the wound as a "Stg II" (Stage 2)
seven days later on September 24, 2010.
Medical record review revealed no further Wound

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DEPARTMENT OF HEALTH AND F. AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		a de la colonia e en a direction a de en da de la colonia de la colonia. En la colonia e en a direction a de en de la colonia de la colonia de la colonia de la colonia de la colonia de	(X3) DATE SURVEY COMPLETED	
		44E200	B. WIN	G		12/2	1/2010
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	Worksheet dated J measurement or st notation "inside rt a crackopen" Medidays later on June Assessment Works coccyxlength 1cm Review revealed no recorded. Record later on June 21, 20 #1 (LPN) documented (by)1cm. Medical review Medical record review assessment compled documented the conflowed 1.0 cm and width 0. Medical record review Assessment Works assessments were 18, and 25. Record August assessment ulcer as a stage 2 molecular as a stage 2 molecular record review Wound Assessment works assessments for the did not include ulcer completed by an Record review revealed the works and one area as "st Record review revealed commented the works assessmented the works and one days later on	ew of the Wound Assessment une 8, 2010 revealed no aging, but a picture with the nd It (right and left) buttock cal record review revealed ten 18, 2010 the Wound sheet documented, " location (centimeter)width1.5 cm." depth or staging was review revealed three days 210, Licensed Practical Nurse ted the coccyx ulcer as Stage the length and width as 1cm x ecord review revealed two July at Worksheets with the last eted July 16, 2010 ccyx ulcer as Stage 2, length 15 cm. The worksheets with the last eted July 16, 2010 wound sheet revealed skin completed on August 6, 17, I review revealed the last two its documented the coccyx measuring .5cm x 0.75cm x The worksheets. The ends of the stage 2 with the ulcer as "stage 2," age 3 with thick white edge."	F 3	14	3) The process of identificate communication regarding assessments was reviewed revised by the DON on 12/3 include weekly skin assessments be completed by each shift's Nurse per the new daily should be reviewed the Thursday clinical meeting clinical IDT which include DON using the wound assert report. The DON will in sereprocess change to licensed 12/31/10.	g skin ed and 31/10 to nents to Charge schedule station. d during g by the des the essment vice this	12-31-10



DEPARTMENT OF HEALTH AND I	AN SERVICES
CENTERS FOR MEDICARE & MEDIC	

PRINTED: 12/29/2010 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	0000		OWB M	<u>0. 0938-039</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DITIPLE CONSTRUCTION DING	(X3) DATE COMP	SURVEY LETED
		44E200	B. WING	9		
	PROVIDER OR SUPPLIER BROOK SANITARIUM	1		STREET ADDRESS, CITY, STATE, ZIP COI 114 CAMPUS DRIVE DAYTON, TN 37321	<u>12/</u> DE	<u>/21/2010</u>
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F 314	Continued From pa	ge 6	F 31	4		
	Assessment Works record.	heets were available in the	F 31	4) The DON will review tracking and communica sheets weekly to	tion report	12-31-10
ir	by the physician relatives the physician relatives was no referent the coccyx. Review physician's progress Nurse Practitioner (Note that the end of the coccyx. Review physician's progress Nurse Practitioner (Note that the coccyx. Review physician's progress Nurse Practitioner (Note that the coccy. Review Practitioner (Note that the coccy would be presented to the presented that the coccyx would be presented to the presented that the coccyx would be presented to the presented that the coccyx would be presented to the presented that the coccyx measurement to the coccyx measurement of the coccys would be presented to the presented that the physician presented the physician presented the physician presented the physician presented the physician presented that the physician presented the physician presented the physician	inote documented by the NP) on November 3, 2010 hip (Decubitus left hip) is e on bottom still open, but ming" Review of the NP's, 2010 revealed "1 Decub. L. estaff request to try O2 nsure if it will help or not." documention regarding the coccyx. In's order dated December 1, buse O2 therapy L hip liy." In's order dated December //et to dry drsg (dressing) to vice daily) X 7 days and In additional record of the was completed October Wound Care Notes and loccyx ulcer was recorded.		documentation, treatment, that the incidence of any has been identified and This review will be done four weeks to ensure department is capturing not and completing document timely manner. Aberrance corrected immediately, will audit 10% of resider skin issues are identified four weeks. These audit continue monthly for three These audit logs will be quarterly by the Quality Committee to include Director, DON, and Adm for further recommendation	orders and new issue addressed weekly for enursing two wounds tation in a les will be the DON ats to sure weekly for logs will e months. reviewed Assurance (Medical inistrator)	

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DEPARTMENT OF HEALT CENTERS FOR MEDICAR	H AND 1 1AN SERVICES E & MEDICAID SERVICES		PRINTED: 12/29/2010 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER	44E200	B. WING	12/21/2010
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LAURE	LBROOK SANITARIUM		114 CAMPUS DRIVE				
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F 314	Continued From page 7	E 314		 			
	Continued From page 7 10, 2010. Medical record review of the Wound Assessment Worksheets for the left hip ulcer revealed an initial assessment on July 16, 2010, with a stage 2 measuring 0.5 cm x 1.0 cm and 0.5 cm depth. Review of the Wound Assessment Worksheet for August 23, 2010 revealed the left hip ulcer was a stage 3 measuring 1.5 cm x 1.0cm x 0.5 cm depth. Review of the Wound Assessment Worksheet for September 24, 2010, revealed the left hip ulcer was a stage 2 measuring 1cm (length) x 1cm (width) and 0.3 (depth). Review of the medical record revealed no further measurements or assessments documented for the left hip ulcer. Observation with Certified Nursing Assistant #1 (CNA) on December 15, 2010 at 11:00 a.m., revealed resident #1 lying in the bed. Observation revealed a large amount of loose bowel movement in the resident's incontinence brief (around the coccyx ulcer). Observation of the coccyx ulcer with CNA #1, after the resident was cleaned, revealed an ulcer immediately	F 314	DEFICIENCY)	DATE			
	above the anal area with more depth at the proximal end and the skin borders surrounding the ulcer had a thick white appearance. During the observation, CNA #1 verified the ulcer did not have a dressing applied. Observation of resident #1's coccyx and left hip pressure ulcers on December 15, 2010, at 11:15 a.m., with Licensed Practical Nurse #1 (LPN) revealed LPN #1 stated, "don't measure woundsdon't know how to measure depth"						

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1			44E200	B. WI	NG		12/3	21/2010
	LAUREL	PROVIDER OR SUPPLIER BROOK SANITARIUM			114	ET ADDRESS, CITY, STATE, ZIP CODE 4 CAMPUS DRIVE AYTON, TN 37321	1211	21/2010
	(X4) ID PREFIX TAG	REGULATORY OR LE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DIII D BE	COMPLETION DATE
	F 314	Interview with LPN # observation revealed coccyx ulcer of 3 cm gauge depth, and LF proximal end was gr Interview revealed the were, "Stage 3" and 1.5 cm length and 0.	f1 at the time of the d a measurement of the a x 1.5 cm and unable to PN #1 agreed depth at the eater than at distal end. The left hip ulcer measured 75 cm width.	F	314			
		(MDS) by telephone 12:50 p.m., revealed MDS assessment har resident #1 on Decer pressure ulcers were During the interview.	nimum Data Set Coordinator on December 16, 2010 at the Coordinator stated and been completed for mber 9, 2010 and the two assessed as Stage 2. The Coordinator stated there essment of the wound a MDS assessment.					
	1	December 16, 2010 a was unaware the coc and stated the ulcer h few weeks." Interview observed the wound o	with the NP by telephone on at 1:50 p.m., the NP stated cyx ulcer had deteriorated, had not been observed in "a v confirmed the NP had not on December 15, 2010, prior by dressing every eight			# 3 3		
	F it h	2. c. Prevent further Plan objectives will be nealing process and to nterventions in the ev nealing, getting larger	ent of a pressure sore not					

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DEPARTMENT OF HEALTH AND H. IN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
			44E200	B. WI	NG		12/2	1/2010
		PROVIDER OR SUPPLIER	I		114	ET ADDRESS, CITY, STATE, ZIP CO 4 CAMPUS DRIVE AYTON, TN 37321		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		policy revealed "V according to a physical according to a physical according to a physical according to a physical according to a physical according to a physical according to a physical according to the and this had not been and this had not been and this had not been according to a physical according to a physical according to the according to the according to the according to the according to the pressure according to the pr	vounds will be treated ician order." Toom with the DON on at 1:15 p.m. verified pressure easured weekly and Weekly Wound Care Notes on completed since October verified the pressure ulcer on been staged since September essure ulcer of the left hip had or staged as required by the September. Interview was completely incontinent of pressure ulcers did not eatment regime ordered to both the ulcers. Interview written an order for a wet to occyx ulcer during an onsite D, 2010. Further interview ure ulcers had not been N, RN, or an LPN who was tage ulcers. Interview ure ulcer on the coccyx had atte from the date of ent time and there had not he treatments except for the ssings and oxygen therapy to Interview confirmed the vent the pressure ulcers from was not followed and	F	314			
		of the pressure ulcers Resident # 15 was a	dmitted on June 30, 2009 ude Closed Head Injury with					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION LIBERTIFICATION NUMBER:			(X2) I		IPLE CONSTRUCTION IG		COMPLETED			
8		44E200	B. WI	ING_			12/21/2010			
	ROVIDER OR SUPPLIER BROOK SANITARIUN	1		1	REET ADDRESS, CITY, S 14 CAMPUS DRIVE DAYTON, TN 37321		4.15			
(X4) ID PREFIX TAG	PERIX (EACH DEFICIENCY MUST BE PRESCUED BY FOLL		(GACH DEFIGIENCY MUST BE PRECEDED BY FULL			CEDED BY FULL PREFIX (EACH CORRECTIVE ACTION			OULD BE	COMPLETION DATE
F 314	Continued From pa Base Skull Fracture Diabetes,	ge 10 , Intracranial Hemorrhage and	F	314		E				
	dated October 14, 2 no problems with sh deficits; decision ma required supervision	ew of the Minimum Data Set 2010 revealed the resident had port or long term memory aking skills was not impaired; n to limited assistance with					ar J			
	chair for mobility, ex both sides of upper was continent of bo			•		(S)				
		ew of the Care Plan, dated evealed the resident had not eing at risk for skin								
	revealed the resider	sed Practical Nurse (LPN) #2 ht required "supervision or vities of daily livingskin her on the right foot from the								
	2010 at 10:35 a.m., resident required the and braces for both apply brace to right the right shoe "built	dent's room on December 20, with the resident revealed the e use of specialized shoes lower legs; was unable to eg by self; had the outside of up" about three to four weeks eeded adjusting now as the				i .	,			
	brace was causing " the social worker ha	sores" on the right foot; and d gotten the resident an the brace adjusted on			e.	 x		*		
	Interview and observing on December 21, 20	vation in the resident's room 10 at 9:40 a.m., with LPN #2								

			DEFIDICACT	Î
F 314	revealed "we're (nursing staff) are putting salve on the blister and padding the area" Observation revealed after removal of the resident's sock and brace, no dressing or padding was present on the resident's foot and the resident had a 1 cm reddened area with dried skin surrounding the reddened area and a pin point open area in the center without drainage located on the upper outer aspect of the right foot and a 2 cm reddened area on the outer ankle which was non-blanchable (did not return to skin tone with pressure).	F 314		
i	Interview confirmed LPN #2 was not aware of the area of skin breakdown on the ankle; was not aware the blister area was now an open area; and confirmed no salve, dressing or padding had been applied.			esting.
	Medical record review of the Progress Note Listing for November 2010 revealed no documentation of the wound on the resident's right foot. Continued review revealed "December 14, 2010 at 10:19 a.m., (Social Services note) Resident requesting to go back to (named clinic) for brace it is rubbing foot causing irritation. Appointment scheduled for December 16, 2010. Resident notified." Continued review revealed "December 20, 2010 at 3:09 p.m., (Social Services note) December 16, 2010 appointment with (named clinic) cancelled due to snow and ce. Appointment rescheduled for December 30 at 11:30 a.m. Resident notified."			
b	Medical record review of the Physician's Progress notes revealed no documentation of skin preakdown for November or December 2010.			
-	fledical record review revealed no documentation			
RM CMS-2567	(02-99) Previous Versions Obsolete Event ID: F01R11	English ID: Third	272	

Event ID: F01R11

Facility ID: TN7201

If continuation sheet Page 12 of 23



DEPARTMENT OF HEALTH AND HU. AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		44E200	B. WING	1100	12/:	21/2010	
	ROVIDER OR SUPPLIER	1	S	TREET ADDRESS, CITY, STATE, ZIP C 114 CAMPUS DRIVE DAYTON, TN 37321			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAĞ	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 314	of periodic or ongoin the medical reconnection the medical reconnection the medical reconnection the medical reconnection revealed documentation on the resident's skin concrevealed no other displayed assessments. Review of the facility revealed "If a resist sore, he/she will reconnect to heal and development of other residents will be assadmission through: (Minimum Data Set during care, 2. Assadentify at risk resid will be evaluated to and to initiate alternevent of a pressure larger or skins of action of the physician will be and provide approping the pressure sore Review of the facility revealed "all resid wounds, and pressure sore Review of the facility revealed "all resid wounds, and pressure sore Review of the facility revealed "all resid wounds, and pressure sore	ng skin assessments present rd. by Wound Tracking Forms ation available: October 10, station on form related to the dition; November 29, 2010 - no he form related to the dition, and December 19, 2010 on form related to the dition. Continued review ocumentation of skin by policy Pressure Sores dentdevelops a pressure ceive appropriate care and nd prevent further er pressure sores1. All sessed for skin integrity upon Nursing assessments, MDS (a), CNA daily observation essments and triggers will ents4. Care Plan objectives monitor the healing process ative interventions in the sore not healing, getting iditional skin breakdown. 5. e in charge of the plan of care riate orders for resolution of	F 31	4			



DEPARTMENT OF HEALTH AND HL .N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		44E200	B. WII	1G		12/2	1/2010	
NO MESONALISMA	PROVIDER OR SUPPLIER	Л		11	EET ADDRESS, CITY, STATE, ZIP CODE 14 CAMPUS DRIVE AYTON, TN 37321			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
F 314	on an ongoing basis the resident to the will be assessed the bathwounds will be physician order. Interview in the sun at 12:25 p.m., with Director of Nursing Minimum Data Set confirmed the facilit of periodic, ongoing comprehensive skir identified as being a Continued interview identify the pressun treatment/services. Continued interview available to indicate the change in the research resident # 5 was addiagnoses to include Mental Retardation,	s and report any changes to charge nurseResidents' skin oroughly during each be treated according to a stroom on December 21, 2010 the Director of Nursing (DON), in Training (DONIT), and and Care Plan Coordinator by did not have documentation	F	314				
	dated August 10, 20 short and long term decision making ski staff and required two positioning in bed, trhygiene and was incobladder. Medical record revieus January 29, 2010 and short short and staff and s	ew of the Minimum Data Set, 210 revealed the resident had memory deficits; impaired alls; was totally dependent on the person assist with ransfers, ambulation and continent of bowel and are wo of the Care Plan, dated and updated on August 10, assident had been identified as						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; F01R11

Facility ID: TN7201

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DEPAR CENTI	RTMENT OF HEALTH	AND AN SERVICES			PRINTE	D: 12/29/201
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE	RM APPROVE O. 0938-039 SURVEY PLETED
		44E200	B. WING_			
	PROVIDER OR SUPPLIER		STI	PEET ADDRESS STATE	12	/21/2010
LAURE	LBROOK SANITARIUM	l = 85	1 1	REET ADDRESS, CITY, STATE, ZIP CODE 14 CAMPUS DRIVE DAYTON, TN 37321		
(X4) ID PREFIX TAG	REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	ALH D DE	COMPLETION DATE
M no do	potential skin breakd redness/discoloration charge nurse if obse physician as needed Interview in the reside 2010 at 10:35 a.m., v (LPN) #2 revealed the assistanceno skin to Interview and observation December 21, 2011 and Certified Nursing revealed "no skin but time revealed the (centimeter) reddened revealed "no skin but time revealed the (centimeter) reddened resh like appearance aspect of upper 1/4 fold with LPN #3 and CNA observation aware of the charge aspect of the charge	kin breakdownMonitor skin ix (signs and symptoms) of down (example: In or open areas). Alert rived for notification of for treatment orders" ent's room on December 20, with Licensed Practical Nurse is resident required "total break down" ation in the resident's room 10 at 9:40 a.m., with LPN #3 Assistant (CNA) #2 reakdown" Observation at resident had a ½ cm di area with a dry abraded or located on the left inner di of the buttocks. Interview #2 confirmed neither had ange in skin condition. of the Progress Note in 11, 2010 at 6:23 p.m., resident has reddened ange in skin condition. of the Progress Note in No open area noted. Turn in No open area noted. Turn in the back to bed immediately is continued review ation related to the	F 314	DATICIENCY)		



STATEMEN	RS FOR MEDICARE IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII	LTIPLE CONSTRUCTION	OMB NO	M APPROV 0. 0938-0
	OF SORRECTION	IDENTIFICATION NUMBER:	A. BUILE		(X3) DATE COMP	SURVEY LETED
NAME OF		44E200	B, WING			
LAUREL	PROVIDER OR SUPPLIER BROOK SANITARIUN		s	STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321		21/2010
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP		COMPLET DATE
fi Franch Market	review of the facility revealed documenta - Skin tear Rt (right) Skin tear Rt arm; No Rt forearm; and Dec documentation on fo skin. Continued revidocumentation of skin. Continued revidocumentation of skin. Continued revidocumentation of skin. Continued revidocumentation of skin. Continued revidocumentation of skin the patient's wounds Forms. Review of the facility a residentdevelops receive appropriate cand prevent further dipressure sores1. Alfor skin integrity upon assessments, MDS (for skin integrity upon adreading, getting larger preakdown. 5. The ptop or resolution of the provention of the provention of the provention of the provention of the provention, and pressure e assessed upon adrospitalizations, the resoroughly reassessed	ew revealed no documentation of skin assessments present d. Wound Tracking Forms tion available: April 16, 2010 forearm; October 10, 2010 - vember 29, 2010 - Skin tear ember 19, 2010 - no rm related to the resident's ew revealed no other in assessment or outcome of on the Wound Tracking policy Pressure Sores "If a pressure sore, he/she will are and treatment to heal evelopment of other il residents will be assessed admission through: Nursing Minimum Data Set), CNA ng care. 2. Assessments fly at risk residents4. Care a evaluated to monitor the oinitiate alternative tent of a pressure sore not or skins of additional skin hysician will be in charge of rovide appropriate orders ressure sore" soriesResident's skin will missionupon return from sident's skin will be lCertified Nursing each resident in their care	F 314	4	ration sheet Pa	ge 16 of 2
skir		redness whenever care is any redness or break in let resident every two				



DEPARTMENT OF HEALTH AND HL ... N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	VIDER/SUPPLIER/CLIA TIFICATION NUMBER: A. BUILDING		PLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY ETED
		44E200	B. WING		- AMARIA	12/21/2010	
3 1000000000000000000000000000000000000	PROVIDER OR SUPPLIER BROOK SANITARIUN	1		11	EET ADDRESS, CITY, STATE, ZIP CODE 4 CAMPUS DRIVE AYTON, TN 37321		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	the resident to the of will be assessed the bathwounds will be physician order. Interview in the sun at 12:25 p.m., with the Director of Nursing Minimum Data Set a confirmed the facility of periodic, ongoing comprehensive skin identified as being a Resident # 11 was a with diagnoses to in Behaviors, Depress Cardiovascular Dise Medical record revied dated November 22 had short and long the impaired decision madependent on staff a assist with positioning hygiene; was non-arrof bowel and bladde Medical record revied November 23, 2010 resident every two he protect bony promine thoroughly on bath divisible/exposed skin being provided. Rep	s and report any changes to charge nurseResidents' skin broughly during each te treated according to a groom on December 21, 2010 the Director of Nursing (DON), in Training (DONIT), and and Care Plan Coordinator y did not have documentation, accurate and assessments on a resident at risk for skin breakdown. Admitted on April 20, 2009 clude Dementia with ion, Hypertension, the and Osteoporosis. Bew of the Minimum Data Set and 32010 revealed the resident term memory deficits; aking skills; was totally and required two person to gin bed, transfers, and inbulatory and was incontinent of the Care Plan, dated revealed "Reposition ours and use pillows to encesassess skin	F:	314			



DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		44E200	B. WING		19/9	1/2010	
	PROVIDER OR SUPPLIER	м		TREET ADDRESS, CITY, STATE, ZIP CO 114 CAMPUS DRIVE DAYTON, TN 37321			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
	Interview in the res 2010 at 10:05 a.m. (LPN) #2 revealed assistanceno skin Interview and obse on December 20, 2 and Certified Nursir revealed "no skin this time revealed treddened area with appearance located upper 1/2 fold of the #3 and CNA #8 and aware of the chang Medical record revipers Note Listing and December 8, 2 documentation of she Medical record revipers Note Listing and December 8, 2 documentation of she Medical record reviews documentation. Review of the facility revealed documentation or resident's skin condition. Review of the facility revealed "If a resident's skin condition or resident's s	ident's room on December 20, with Licensed Practical Nurse the resident required "total in break down" rvation in the resident's room 2010 at 1:30 p.m., with LPN #3 ing Assistant #8 and #9 is breakdown" Observation at the resident had a 1 cm is a dry abraded or rash like id on the right inner aspect of buttocks. Interview with LPN if #9 confirmed neither was in skin condition. ew of the last documented ing dated November 25, 2010 2010 revealed no identify the Physician's Progress on available for November and realed no documentation of its y Wound Tracking Forms action available: April 16, 2010, and December 19, 2010 with in the forms related to the ition. If y policy Pressure Sores dentdevelops a pressure eive appropriate care and id prevent further er pressure sores1. All	F 31				
	residents will be ass admission through; I	essed for skin integrity upon Nursing assessments, MDS					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: F01R11

Facility ID: TN7201

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DEPARTMENT OF HEALTH AND HU. .N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		3 dem de a 200 de contra d	(X3) DATE SURVEY COMPLETED	
		44E200	B. WING		12/21/2010		
	ROVIDER OR SUPPLIER		_1	1	REET ADDRESS, CITY, STATE, ZIP CODE 14 CAMPUS DRIVE DAYTON, TN 37321	1212	1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 314	during care. 2, Assidentify at risk residentify and to initiate alternevent of a pressure larger or skins of at The physician will be and provide approphing the pressure sore Review of the facility revealed "all resident revealed "all resident revealed "all resident and provide assessed upon hospitalizations, the thoroughly reasses Assistants will assessed on an ongoing basis the resident to the will be assessed the bathwounds will be physician order.	t), CNA daily observation sessments and triggers will lents4. Care Plan objectives monitor the healing process native interventions in the sore not healing, getting dditional skin breakdown. 5. The in charge of the plan of care oriate orders for resolution of the plan of care oriate orders for resolution of the plan of care dents will be free from tears, the soresResident's skin will admissionupon return from the resident's skin will be sedCertified Nursing the seach resident in their care is and report any changes to charge nurseResidents' skin oroughly during each the treated according to a troom on December 21, 2010	F	314			
	at 12:25 p.m., with Director of Nursing Minimum Data Set confirmed the facilit of periodic, ongoing comprehensive skir identified as being a Continued interview	the Director of Nursing (DON), in Training (DONIT), and and Care Plan Coordinator by did not have documentation					
F 323 SS=D	483.25(h) FREE OF HAZARDS/SUPER	ACCIDENT VISION/DEVICES	F	323			
	The facility must en	sure that the resident					



DEPARTMENT OF HEALTH AND F"	'AN SERVICES
CENTERS FOR MEDICARE & MEL	AID SERVICES

PRINTED: 12/29/2010 FORM APPROVED OMB NO. 0938-0391

STATEM	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(2/0)	41.17.55		CINIBIA	IO. 0938-039	9
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		TPLE CONSTRUCTION			
		44E200	B. WIN	NG_		in-serviced CNA's on Plan of Care on resident that they are a two person times when not in bed or ed thigh restraints in pleted 12/31, written interial placed into interial plac		
NAME O	F PROVIDER OR SUPPLIER					12	2/21/2010	
1	ELBROOK SANITARIUM	Λ		1	REET ADDRESS, CITY, STATE, ZIP CODE 14 CAMPUS DRIVE DAYTON, TN 37321			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES						
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		CROSS-REFERENCED TO THE APPR	LILDEE	COMPLETION DATE	N
F 32	F 323 Continued From page 19		F3	122	F323			-
	environment remain as is possible; and e	ns as free of accident hazards each resident receives on and assistance devices to	rs	523	1) DON re-in-serviced CNA following Plan of Care on res#3 and using a sling to transferesident. DON re-in-service	sident er CNA's	12-31-10	,
	This DEOLUDEMEN	- 0. success			on following Fight of Care for	,		ı
	by:	T is not met as evidenced		1	resident #8 that they are a two	dent #8 that they are a two person		
	Based on medical re	poord review at a second		1	assist at all times when not in	bed or	6.58	
	interview the facility	ecord review, observation and failed to provide assistive		-	in specialized thigh restraints	in		1
	devices/hands on co	intact to provide assistive			chair. Completed 12/31, writt	en in-		
	devices/hands on contact to prevent falls for two (#3, #8) of twenty three residents reviewed.		(2)		serviced material placed into	in_	1	
	l l l l l l l l l l l l l l l l l l l	of redidents reviewed.			service book to be read and a	anad		1
	The findings included	d;			by staff not in attendance.	gned		1
	De-14-14	CONTRACTOR CONTRACTOR CONTRACTOR			2) Floor Supervisor and d	¥¥		1
	Resident #3 was adn	nitted to the facility on April			Care Plan short that it	ını		
	Cerebrovascular Ace	ses including Hypertension,	8	1	Care Flan sheets that includes	the		1
	and a history of contr	ident, Right Hemiparesis			care plans for each teams resid	lents.		ı
	i i	actures.			This is to be located in the CN	A care		l
	Review of the Minimu	ım Data Set dated May 4,			plan binder at the nurse's stati	on.		I
	2010, (Prior to the res	sident's injuries) revealed the		1	CNA's will carry these mini carry	are		ı
	resident was non-am	bulatory and required		1 8	plan sheets with them during s	hift		1
	assistance of two stat	f for transfer the resident			and refer to them when they ha	ive		l
	memone difficulty with	y with long and short term			questions regarding Plan of Ca	re for		
	required total care for	n decision making skills and all activities of daily living.			their residents.	10 101		
		an activities of daily living.						
	Review of the plan of	care updated July 7, 2010		1	compliance by your and a deal	or		
	revealed the resident	required the use of a sling		1	compnance by randomly choos	ing 2		
1	for all transfers.				call and verifying CNA's	are	1	
Í	Observation 5				lonowing the plan of care. Thi	s will	1	
ĺ	revealed the resident	nber 14, 2010 at 12:45 p.m.			be monitored weekly (Wednesd	iay) x	1	
	resident's room forms	seated in a geri chair in the		4	4 weeks and then monthly x 2			
	lower extremities in the	the back wall, with the		1	months.			
		= up position.		1	4) DON to report compliance to	204		
		1		1	Committee	, AV		

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Event ID: F01R11

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DEPARTMENT OF HEALTH AND F. AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100	IULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
44E200		44E200	B. WING			12/21/2010	
	PROVIDER OR SUPPLIER		•	114	ET ADDRESS, CITY, STATE, ZIP CODE 4 CAMPUS DRIVE AYTON, TN 37321		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	0.700.00	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Observation on Decrevealed two CNA's in the resident's roo resident from the geobservation reveale under the resident's under the contracter resident from the geometric from the geomet	cember 15, 2010 at 9:15 a.m. (Certified Nursing Assistants) in preparing to transfer the eri chair to the bed. Continued dithe CNA's placed their arms arm pits, holding the resident dilegs, and transferred the eri chair to the bed. ew) Director of Nursing on at 11:45 a.m., at the nursing eresident required a sling for mitted to the facility on this diagnoses including the convulsions, accident and Seizures. um Data Set dated July 6, esident was an extensive rson transfer and ambulation.	F	323	DEPOLENCY)		
	forward and fell from caused a laceration a ofhead along the same not deep and does no treatment" Review of facility doo investigation revealed	chair hittingheadFall about 1 ½ inches on the top agital suture lineLaceration of require emergency umentation and post incident d "an observed fallon at 8:15 p.m., the resident					
i i	eaped forward out of	f(special) chairresident					

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Event ID: F01R11

Facility ID; TN7201

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DEPARTMENT OF HEALTH AND AND SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							ED: 12/29/201 RM APPROVE	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		IPLE CONSTRUCTION	(X3) DATI	IO. 0938-039 E SURVEY PLETED	
		44E200	B. WIN	G_		١		
LAUREL	PROVIDER OR SUPPLIER			1.	REET ADDRESS, CITY, STATE, ZIP CODE 14 CAMPUS DRIVE AYTON, TN 37321	12/21/2010		
(X4) ID PREFIX TAG	(GACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	:	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	IIIDEE	(X5) COMPLETION DATE	
F 323	hit the floor causing head" Continued nevealed the plan of caring for (the reside at all times to prever forward while unclan CNA's to get supplie starting care." Continued ocumentation revealed.	a 1 ½ inch laceration to top of eview of the documentation correction stated "When ent) there should be hands on the testident of the resident of the resid	F 3;	23				
	of a special chair with daily use as a restrain	nt's care plan dated January le resident required the use n attached thigh straps for nt; padded side rails up at all times, and a clip alarm				2 0 4 2		
1	p.m., revealed two Ce (CNAs) in the residen provide incontinence Continued observation removed the alarm an	care for the resident. In revealed the CNAs and thigh straps and lifted the lines to a standing position.					e 2	
ti	11.02 a.m., by phone !	on December 21, 2010, at stated the clip alarm and removed at the time of the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Interview with the Director of Nursing on December 21, 2010, at 11:30 a.m., in the

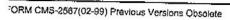
Event ID; F01R11

Facility ID: TN7201

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DEPAR	TMENT OF HEALTH	AND 1 1AN SERVICES			PRINTED): 12/29/2010	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM	APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
44E200			B. WING				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		12/21/2010	
LAURELBROOK SANITARIUM			12 13	114 CAMPUS DRIVE DAYTON, TN 37321	ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OFFICIENCY (X5) COMPLETION DATE		
F 323	director's office cont person transfer and hands of contact at a	firmed the resident was a two the facility had implemented any time the resident's leg	F3	323			



Event ID: F01R11

Facility ID: TN7201

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